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In the Supreme Court of the United States

DAVID KING, et al.,

Petitioners,

v.

SYLVIA BURWELL, Secretary of Health and Human Services, et al.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF THE *AMICUS CURIAE*

Amicus America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance industry.[1] Along with its predecessors, AHIP has over fifty years of experience in the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans, offering a wide range of insurance options to consumers, employers of all sizes, and governmental purchasers. As a result, AHIP's members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's healthcare and health insurance systems and a unique understanding of how those systems work.

Health insurance plans are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* and its counsel made a monetary contribution to its preparation or submission. The parties' letters consenting to the filing of *amicus curiae* briefs have been filed with the Clerk's office.

of 2010, Pub. L. No. 111–152, 124 Stat. 1029 ("ACA"). AHIP has participated as *amicus curiae* in other cases to explain the practical operation of the ACA.[2] Likewise here, because other briefs address the legal standards applicable to this appeal, AHIP seeks to provide the Court with its expertise regarding the operation of the health insurance market, the changes made by the ACA, the objectives those changes advance, and the foreseeable consequences that would follow from precluding access to the ACA's premium assistance tax credits in the 34 States in which consumers purchase individual insurance through a federally facilitated exchange ("FFE"). This perspective will provide the Court with a more detailed understanding of the practical consequences of the construction of the statute urged by Petitioners and their *amici*.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Affordable Care Act fundamentally changed our Nation's system of health insurance. The individual health insurance market prior to the ACA—other than in the few States that had implemented their own variants of healthcare reform—was based

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[2] Br. of AHIP as *Amicus Curiae* in Support of Defendants-Appellees and Affirmance, *Halbig* v. *Burwell*, 758 F.3d 390 (D.C. Cir. 2014) (No. 14–5018), 2014 WL 605451; Br. of AHIP as *Amicus Curiae* in Support of Defendants-Appellees and Affirmance, *King* v. *Burwell*, 759 F.3d 358 (4th Cir. 2014) (No. 14–1158), 2014 WL 1093824; Br. of AHIP and Blue Cross Blue Shield Ass'n as *Amici Curiae* on Severability 27–33, *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566 (2012) (No. 11–393), 2012 WL 72449; Br. for AHIP as *Amicus Curiae* in Support of Neither Party, *Virginia ex rel. Cuccinelli* v. *Sebelius*, 656 F.3d 253 (4th Cir. 2011) (No. 11–1057), 2011 WL 795219.

on individualized assessments of risk. Consumers seeking individual health insurance—like consumers purchasing life insurance and auto insurance—shopped for and purchased insurance policies with availability, scope of coverage, and price determined on the basis of the consumer's own personal circumstances.

The ACA employed three types of reforms to accomplish its goal of making quality, affordable health insurance available to more Americans: (1) insurance market reforms, including "guaranteed issue" (which means that no one can be denied insurance based on individual characteristics, including preexisting health conditions), "adjusted community rating" (which means that premiums may vary based only on age, geography, family size, and tobacco use), and minimum coverage requirements (which mandate that policies at least provide specified types of coverage); (2) personal responsibility for obtaining health insurance, reinforced by a tax penalty when individuals fail to obtain minimum essential insurance coverage (the "shared responsibility requirement"); and (3) premium tax credits to make the mandated coverage affordable for low- and middle-income individuals and families.

These three elements work together to create a viable insurance market based on broad consumer participation. Because the market reforms effectively eliminate risk-based underwriting based on the individual consumer's characteristics, risk must be spread across a demographically-balanced pool of insureds, particularly individuals of different ages who are likely to incur different levels of medical expenses.

Without these three interconnected provisions, only those who expect to incur substantial healthcare costs would participate in the individual market, which would in turn push up the average medical cost incurred by that pool of insureds, leading to a so-called "death spiral" of premium increases and market contraction. If the shared responsibility requirement and premium tax credits did not work hand-in-hand with the market reforms, the ACA's reforms would lead to unstable markets with fewer affordable options for individual health insurance in the 34 States with federally-facilitated exchanges than what was available before enactment of the ACA. In other words, the effect of the ACA in these States would not be to increase insurance availability or to leave insurance availability the same, but rather to make the situation worse than it was before Congress acted.

The phenomenon producing this result, known as "adverse selection," is well recognized in the literature and features prominently in the analysis of the ACA by the American Academy of Actuaries. It occurred in conjunction with a series of failed pre-ACA health insurance reform efforts in the States (described *infra* at 10–12), which demonstrate that when market reforms are enacted without a shared responsibility requirement or tax incentives, the result is an ever-shrinking market in which only the very sick ultimately find it advantageous to purchase health insurance.

This understanding extends beyond the literature. Indeed, despite reaching divergent conclusions on the permissibility of granting tax credits for plans purchased on federally-operated exchanges, the federal appellate courts recognize the very real threat

adverse selection poses to the viability of the exchanges and of individual insurance markets more generally—and the integral role tax credits play in containing it. See, *e.g.*, *King* v. *Burwell*, 759 F.3d 358, 375 (4th Cir. 2014) (acknowledging the threat of adverse selection and concluding that "the economic framework supporting the [ACA] would crumble if the [tax] credits were unavailable on" federally-operated exchanges); *Halbig* v. *Burwell*, 758 F.3d 390, 412 (acknowledging that a ruling invalidating tax credits for plans purchased through federally-operated exchanges "will likely have significant consequences both for the millions of individuals receiving tax credits through federal Exchanges and for health insurance markets more broadly"), *vacated for reh'g en banc*, 2014 WL 4627181 (D.C. Cir. 2014).

Premium tax credits (and the related shared responsibility payments) are essential components of an actuarially-viable marketplace because of their integral relationship to the ACA's market reforms. There is no practical reason to distinguish between State- and federally-operated exchanges in this regard. The ACA's shared responsibility obligation and eligibility for premium assistance tax credits are governed by nationally-established standards with payment from the federal treasury, regardless of which sovereign administers the particular exchange. It makes no difference to the market reforms whether the exchange is State- or federally-operated. Likewise from the perspective of consumers, State- and federally-operated exchanges perform the same basic functions—facilitating the comparison of plan choices, the determination of eligibility, and the enrollment process.

Delinking the three integrated components of the ACA's reform package in States with federally-facilitated insurance exchanges would create severely dysfunctional insurance markets in those 34 States, significantly disadvantaging millions of consumers in those States. Far beyond the question of whether certain individuals could obtain subsidies on their premiums, the lack of tax credits in the FFEs would alter the fundamental dynamics of those markets in a manner that would make insurance significantly less affordable even to those who would not rely on subsidies. It would leave consumers in those States with a more unstable market and far higher costs than if the ACA had not been enacted.

ARGUMENT

Premium Assistance Tax Credits In Federally Facilitated Exchanges Are An Essential Safeguard Against The Destabilization And Failure Of These Insurance Markets.

The Affordable Care Act employs three integrated reforms to create a new framework for the individual health insurance marketplace—standards governing availability, coverage, and pricing of insurance (the "market reforms"); shared responsibility payments; and premium tax credits to help low- and middle-income individuals purchase insurance policies. See *infra* Section A. Severing the shared responsibility payments and the tax credits from the market reforms in the States with FFEs would prevent the creation of the balanced risk pools that are essential for the proper functioning of these markets.

Young and healthy individuals would opt out of the exchanges and millions of low- and middle-income families would become exempt from the

ACA's shared responsibility payments. The resulting individual health insurance markets would be unstable in the 34 States with FFEs,[3] producing a deleterious impact on the residents of those States. See *infra* Section B.[4]

A. The Shared Responsibility Payments And Premium Tax Credits Are Essential To Create The Broad Risk Pools Needed For Proper Functioning Of The Market Reforms.

The Affordable Care Act took a comprehensive approach to reform. Recognizing the key elements of a well-functioning insurance market—and the critical importance of a balanced risk pool—the statute pairs reforms that increase availability of health insurance and decrease disparities in premiums with tax credits and a financial penalty for failing to purchase insurance, a combination essential to produce well-functioning markets.

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[3] Those States are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

[4] There are three primary markets for health insurance: large group, small group, and individual (sometimes called nongroup). See 42 U.S.C. § 18024(a). The tax credits at issue in this case apply only to the individual market. See 26 U.S.C. § 36B(b)(2)(A).

1. A balanced risk pool is essential for a stable health insurance marketplace.

Like all forms of insurance, health insurance is based on the pooling and transfer of risks. Individuals' future healthcare expenses are unpredictable; the purpose of insurance is to transfer from the individual to the insurer the risk of an unanticipated and unaffordable spike in medical costs. An insurer aggregates risk into a larger pool and spreads that risk by setting premiums that reflect the average risk in the pool.

Prior to the enactment of the ACA, insurers had to employ a number of tools to prevent development of unbalanced risk pools in the individual insurance market. In particular, applicants were "underwritten to determine their insurability, and * * * charged higher or lower premiums based on age and health status."[5]

When individuals' premiums for health insurance *do not* reflect such risk-based underwriting, the economic phenomenon of "adverse selection" is likely to occur.[6] As the ACA's statutory findings explain, strong incentives exist for people at low risk of significant healthcare needs and expenses to "make an economic and financial decision to forego health in-

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[5] Nat'l Ass'n of Ins. Comm'rs, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* 1 (2011), http://www.naic.org/store/free/ASE-OP.pdf; see also Kathryn Linehan, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 4–6 (Nat'l Health Pol'y Forum Background Paper No. 69, 2009), http://www.nhpf.org/library/background-papers/BP69_UnderwritingNonGroup_06-04-09.pdf.

[6] See Linehan, *supra* note 5, at 4.

surance coverage and attempt to self-insure." 42 U.S.C. § 18091(2)(A). Particularly if individuals are guaranteed that they will be able to purchase insurance at a set price, many will "wait to purchase health insurance until they need[] care." *Id.* § 18091(2)(I).

The consequences of adverse selection are extremely significant. "When healthier individuals perceive no economic benefit to purchasing coverage, the insurance pool becomes increasingly skewed to those with higher expected claims."[7] Because premiums are a function of the average expected payout of benefits to pool participants, an upward shift in the risk profile of the pool will lead to increased premiums for all participants in that pool.[8]

Left unaddressed, adverse selection will destabilize insurance markets in an adverse-selection "death spiral." When healthy individuals opt out of the individual insurance market, those who are left are, on average, less healthy (and therefore prone to higher-than-average medical expenses). A sicker pool of consumers results in higher premiums, which causes an additional relatively healthy subset of participants to drop out, which in turn results in a further increase in premiums.[9]

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[7] See Am. Acad. of Actuaries, *Critical Issues in Health Reform: Risk Pooling* 1 (July 2009), http://www.actuary.org/pdf/health/pool_july09.pdf.

[8] See Linda J. Blumberg & John Holahan, *Do Individual Mandates Matter?* 2 (Urban Inst. 2008), http://www.urban.org/UploadedPDF/411603_individual_mandates.pdf.

[9] Katherine Swartz, *Sharing Risks, How Government Can Make Health Insurance Markets More Efficient and More Affordable*, THE ECONOMICS OF RISK 117 (Donald J. Meyer, ed.,

This effect is particularly pronounced for health insurance, because the individuals who know that they will require substantial amounts of medical care—*i.e.*, those who are most likely to benefit from risk-sharing and most likely to seek insurance—have much greater medical costs. Nearly one-half of all medical expenditures are made on behalf of the sickest 5% of the population, while the healthier half of the population accounts for only 3% of medical expenses.[10]

The perils of adverse selection are not merely theoretical. History shows that market reforms implemented without requiring that individuals purchase insurance or pay a penalty and without premium subsidies produce adverse selection. Thus, prior reforms in Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington that prohibited risk-based underwriting but did not require the purchase of insurance or provide other significant incentives for obtaining insurance resulted in markets with "death spiral" characteristics.[11]

In Washington, for example, the Legislature reformed the individual health insurance market

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2003); see also Am. Acad. of Actuaries, *Critical Issues in Health Reform: Market Reform Principles* (2009), http://www.actuary.org/pdf/health/market_reform_may09.pdf.

[10] Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures* 2–3 (Agency for Healthcare Research & Quality Pub. No. 06-0060, 2006), http://www.ahrq.gov/research/findings/factsheets/costs/expriach/expendria.pdf.

[11] See Br. of AHIP and Blue Cross Blue Shield Ass'n as *Amici Curiae*, *supra* note 2, at 27–33. Although Massachusetts is recognized as a model for the Affordable Care Act, there was a prior, failed reform attempt dating to 1996. *Id.* at 31–32.

in 1993 to guarantee that residents could purchase insurance based on community—and not individual—rates.[12] During the first three years, premiums in Washington's individual health-insurance market increased by 78 percent.[13] Enrollment fell by 25 percent.[14] By September 1999—six years after the reforms had been introduced—all but two of the State's nineteen private health insurers had withdrawn from the market, and the last two had announced their intention to withdraw. "[T]he individual market had essentially collapsed."[15] Washington repealed the market reforms in 2001.[16]

New York experienced a similar dynamic. In 1992, the Legislature reformed the health-insurance market by guaranteeing the issuance of insurance at community-based rates. These reforms prompted a "sharp decline" of the individual insurance market.[17] In 1992, 1.2 million New Yorkers

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[12] Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. HEALTH POLITICS, POLICY & LAW 133, 136–37 (2000).

[13] See Peter Suderman, *The Lesson of State Health-Care Reforms*, WALL ST. J., Oct. 15, 2009, at A21.

[14] Roger Stark, *Overview of the Individual Health Insurance Market in Washington State* 1 (Wash. Pol'y Ctr. Jan. 2011).

[15] *Id.*; see also Conrad F. Meier, *Universal Health Insurance in Washington State: A Grim Prognosis for All of Us*, Med. Sentinel (Mar./Apr. 2000).

[16] See Jill Bernstein, *Issue Br.: Recognizing Destabilization in the Individual Health Insurance Market* 4 (Robert Wood Johnson Found. July 2010).

[17] Paul Howard, *Building a Market-Based Health-Insurance Exchange in New York* 7 (Ctr. for Med. Progress 2011), http://nyshealthfoundation.org/uploads/resources/market-based-health-insurance-exchange-april-2011.pdf.

purchased individual insurance policies.[18] But premiums had increased 35–40% by 1996.[19] By 2010, only 31,000 New Yorkers remained in the individual insurance market—a decrease of 97%.[20] At that point, the only people who participated in the market were those who were "very sick (and affluent)."[21] Those reforms thus made health insurance cost and availability considerably worse, rather than better, and the flaws of those failed attempts are now well understood.[22]

2. The Affordable Care Act's reforms include features critical to promoting market stability.

The Affordable Care Act imposed nationwide minimum standards governing availability, coverage scope, and pricing of individual policies, which bar insurers from using the tools that they previously had employed to manage and price their risks and to ensure market stability. To prevent market destabilization, the ACA coupled those changes with new measures designed to promote balanced risk pools and to deter adverse selection.

These reforms—the prohibition of prior tools used to manage risk pools and the adoption of shared

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[18] See Sarah Lyall, *Bill to Overhaul Health Insurance Passes in Albany*, N.Y. TIMES, July 2, 1992, at A1.

[19] Stephen T. Parente & Tarren Bragdon, *Why Health Care Is So Expensive in New York*, WALL ST. J., Oct. 16, 2009.

[20] *Id.*

[21] Howard, *supra* note 17, at 7.

[22] See, *e.g.*, 42 U.S.C. § 18091(2)(I) (acknowledging the need to "minimize * * * adverse selection and broaden the health insurance risk pool to include healthy individuals").

responsibility payments and tax credits—constitute a single integrated package. None of the reforms, standing alone, would result in a healthy and sustainable marketplace for insurance. Rather, as a prominent scholar in healthcare economics explained at the time, the exchanges were built on "a three-legged stool that is useless without all three legs."[23]

a. *Insurance market reforms.*

The ACA contains one set of reforms that significantly alters relationships between insurers and consumers. These reforms ensure that all individuals have access to health insurance for which premiums are assessed at the *community*-level rather than based on *individual* risk factors.

Guaranteed issue. The ACA provides that "each health insurance issuer * * * must accept every * * * individual in the State that applies for such coverage." 42 U.S.C. § 300gg–1. Prior to the ACA, insurers were able to construct risk pools that included only individuals with characteristics specified by the insurer. Thus, individuals who were previously deemed uninsurable based on their individual characteristics (*e.g.*, pre-existing conditions) are guaranteed to be issued healthcare coverage. See also 42 U.S.C. § 300gg–4 (prohibiting eligibility rules based on enumerated "health status-related factors").

Adjusted community rating. The ACA changed the methodology for calculating premiums. Prior to the ACA, premiums could be calculated on the basis

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[23] Uwe E. Reinhardt, *Lost in the Shuffle: The Overarching Goals of Health Reform*, N.Y. TIMES ECONOMIX BLOG (Aug. 7, 2009), http://economix.blogs.nytimes.com/2009/08/07/lost-in-the-shuffle-the-overarching-goals-of-health-reform.

of a variety of factors related to the insured's risk of incurring medical expenses, including gender (with younger females paying more than younger males[24]), age (with older tiers of Americans paying more than younger tiers[25]), and personal health histories. Under the ACA, only four factors may be considered: (1) whether a plan covers an individual or a family; (2) the geographical area; (3) the consumer's age; and (4) tobacco use. 42 U.S.C. § 300gg(a)(1)(A). The ACA caps age-based variations by a 3-to-1 ratio. See 42 U.S.C. § 300gg(a)(1)(A)(iii). As a result, health insurance is relatively more affordable for older Americans, but relatively more expensive for younger Americans. Likewise, premiums for younger males have become relatively more expensive and premiums for younger females have become relatively less expensive.

Prohibition on pre-existing medical condition exclusions. The ACA prohibits insurers from excluding pre-existing medical conditions or imposing a waiting period before their coverage. 42 U.S.C. § 300gg–3. Prior to the ACA, insurers mitigated risk in the individual market by issuing policies that excluded coverage for pre-existing medical conditions, either temporarily or permanently.[26] Therefore, persons with

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[24] Robert Pear, *Gender Gap Persists in Cost of Health Insurance*, N.Y. TIMES, Mar. 19, 2012.

[25] Robert Wood Johnson Found., *Implications of Limited Age Rating Bands Under the Affordable Care Act* 1 (2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404637/subassets/rwjf404637_1.

[26] See Henry J. Kaiser Family Found., *Health Insurance Market Reforms: Pre-Existing Condition Exclusions* (Sept. 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8356.pdf.

pre-existing medical conditions now have greater incentives to participate in the healthcare exchanges.

Minimum coverage requirements. The ACA requires individual insurance plans to offer government-specified "essential health benefits," which include items and services in ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. 42 U.S.C. §§ 300gg–6, 18022. These policies must cover at least 60 percent of anticipated medical expenses (known as actuarial value) with statutorily-determined ceilings on out-of-pocket payments by consumers. Before the statute's enactment, consumers could purchase policies tailored to their limited needs. As a result of the minimum coverage requirements and the minimum actuarial value requirements, previously popular low-premium, less comprehensive policies are unavailable under the ACA.[27]

b. *Reforms to create a balanced risk pool.*

Congress recognized that the insurance market reforms, unaccompanied by corresponding incentives

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[27] See also 42 U.S.C. § 18022(d)(2) (prescribing requirements for actuarial value). Individuals are eligible to enroll in an insurance plan with a higher deductible (that therefore has a lower actuarial value) if they are younger than 30 years old or are exempt from shared responsibility payments. *Id.* § 18022(e).

for broad participation in the market, would have produced unstable insurance exchanges. If the market reforms—forbidding premium insurance availability based on preexisting conditions or health status—stood alone, then, Congress concluded, "some individuals would make an economic and financial decision to forego health insurance coverage" (42 U.S.C. § 18091(2)(A)), and "would wait to purchase health insurance until they needed care" (*id.* § 18091(2)(I))—the equivalent of purchasing auto insurance after an accident. A well-functioning insurance pool must include low-risk individuals to balance the medical costs of high-risk individuals, but the insurance market reforms, standing alone, would attract high-risk individuals and deter participation by low-risk individuals.

Healthy and young Americans, who traditionally have opted-out of the insurance market at disproportionate rates,[28] face increased premiums compared to premiums in the pre-ACA insurance markets as a result of community rating. And persons with chronic pre-existing conditions who otherwise might have been uninsurable are now eligible for insurance at the same premiums as persons in good health. The ACA includes incentives for obtaining insurance (and disincentives for declining to carry insurance) that collectively "minimize this adverse selection and broaden the health insurance risk pool to include

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[28] Christina Postolowski & Abigail Newcomer, *Helping Students Understand Health Care Reform and Enroll in Health Insurance* (2013), http://health.younginvincibles.org/wp-content/uploads/2013/09/ACA-Toolkit_Helping-Students-Understand-Health-Care-Reform-and-Enroll-in-Health-Insurance.pdf ("Young adults ages 18 to 34 are uninsured at almost double the rate of older adults.").

healthy individuals." 42 U.S.C. § 18091(2)(I). Indeed, these requirements "together * * * will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured." *Id.* § 18091(2)(C).[29]

Shared responsibility payment obligation. To maximize the number of younger and healthier individuals who participate in the market for individual health insurance, the ACA requires individuals to obtain minimum essential healthcare coverage or to make a shared responsibility payment through the tax system. Those payments—which vary based on an individual's household income—create additional costs for those who might otherwise choose not to enroll in healthcare insurance coverage and thus incentivize enrollment.[30] Congress expressly found that this obligation "is *essential* to creating effective

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[29] By decreasing the number of uninsured individuals, these reforms have a host of collateral effects, including: (i) limiting economic losses—estimated at roughly $207 billion yearly—associated with "the poorer health and shorter lifespan of the uninsured" (42 U.S.C. § 18091(2)(E)); (ii) "significantly reduc[ing] administrative costs"—estimated at $90 billion in 2006—and "lower[ing] health insurance premiums" by "increas[ing] economies of scale" (42 U.S.C. § 18091(2)(J)); and (iii) limiting the extent to which health care providers must pass onto insured individuals costs that uninsured individuals impose when they do seek care (see 42 U.S.C. § 18091(2)(F)).

[30] After a phase-in period that ends in 2016, persons who fail to carry minimum essential coverage will owe an annual tax equal to the greater of $695 or 2.5% of household income in excess of the IRS's threshold for filing a tax return ($10,300 for an individual for tax year 2015). See 26 U.S.C. §§ 5000A, 6012(a)(1)(A)(i); Rev. Proc. 2014–61, 2014–47 I.R.B. 860.

health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I) (emphasis added).

Premium tax credits. The ACA pairs the shared responsibility payment obligation with a system of premium tax credits for low- and middle-income Americans. Just as the penalty for nonparticipation imposes a cost on those who opt out of health insurance, tax credits lessen the financial burden on these individuals (as in other circumstances in which the government uses tax policy to promote desired conduct, such as the tax advantages for employer-provided health insurance).

Prior to passage of the ACA, the Congressional Budget Office estimated that the vast majority of all exchange enrollees—78%—would be entitled to premium assistance tax credits.[31] Actual enrollments from the initial open enrollment period exceeded those estimates, with 85% of enrollees claiming subsidies.[32] Those enrollees received an estimated average tax credit of $4,410 per enrollee in 2014.[33]

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[31] See Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 24 (Nov. 30, 2009).

[32] See ASPE Issue Br., *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* 9 (May 1, 2014), http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

[33] See Cong. Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* 4 tbl. 2 (Apr. 2014), http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

These credits play an especially important role because the ACA's minimum coverage requirements, minimum actuarial value requirements, new premium taxes,[34] and new adjusted community rating rules make unavailable less-costly insurance that was purchased by many consumers prior to enactment of the reform law. To achieve the goal of a broader risk pool, the tax credits were calibrated to offset the additional costs resulting from these new requirements. The credits also address the tax disadvantage suffered by individuals and families who purchase insurance on their own, and therefore do not receive the tax preference accorded to employer-based coverage.[35]

The statute provides that individuals with household incomes less than 400% of the federal poverty limit (in 2015, $47,080 for an individual or $97,000 for a family of four[36]) are entitled to tax credits (26 U.S.C. § 36B) that immediately reduce their premiums for health insurance purchased through an exchange (42 U.S.C. § 18082(c)(2)).

The combination of tax credits and shared responsibility payments encourage individuals to participate in the individual health insurance market who otherwise would remain uninsured. That is particularly true for young and healthy individuals who might not otherwise perceive a sufficient economic benefit from insurance. The tax credits can be sub-

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[34] See, *e.g.*, 42 U.S.C. § 18061; 26 U.S.C. note preceding § 4001.

[35] See 26 U.S.C. § 106(a) (excluding employer-provided health plans from gross income).

[36] See Annual Update of HHS Poverty Guidelines, 80 Fed. Reg. 3236 (Jan. 22, 2015).

stantial—they are expected to average $4,330 in 2015.[37] And individuals who have purchased plans through the FFEs have experienced, on average, a seventy-six percent reduction in their premiums as a result of the tax credit.[38]

Moreover, the tax credits work in tandem with the shared responsibility payment obligation. That is because no payment obligation attaches when insurance cost would exceed 8% of household income after government contributions. 26 U.S.C. § 5000A(e)(1). In the absence of the tax credits, a large portion of the population would fall within that exempt category, because there would be no tax credits to reduce the insurance cost to the 8%-or-below level.[39] That would significantly undermine the incentive structure provided by the shared responsibility payments and the tax credits, which is necessary to achieve broad participation and balanced risk pools in the individual insurance markets.

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[37] See Cong. Budget Office, *The Budget and Economic Outlook: 2015 to 2025* 119 tbl. B-2 (January 2015), https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf.

[38] ASPE Research Br., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace* 2 (June 18, 2014), http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

[39] The tax credits are also tied to the so-called "employer mandate" as well. See 26 U.S.C. § 4980H(b) (imposing shared responsibility payment of $3,000 per year for large employers for each employee who receives a tax credit). Although beyond the scope of this brief, the link between tax credits and the health-insurance incentives for large employers underscores the interconnected nature of the ACA's reforms.

* * *

In sum, the ACA took away certain tools for managing risk but introduced new mechanisms for assuring a stable risk pool by keeping adverse selection in check. The tax credits and the shared responsibility payments are essential components of a sustainable private market for insurance.

B. If Tax Credits Were Unavailable In Federally Facilitated Exchanges, The Risk Pool Would Skew Significantly Toward High-Risk Individuals.

Eliminating premium assistance tax credits for participants in the federally-facilitated exchanges ("FFEs") would undermine the ACA's central goal of achieving stable insurance markets based on a broad risk pool containing an appropriate mix of low-risk and high-risk individuals. Indeed, it would leave States with FFEs with individual insurance markets far more dysfunctional than before the ACA was enacted.

The 34 States in which the exchange is facilitated by the federal government contain 68% of those nationwide who enrolled in health insurance through an exchange as of the close of the initial open enrollment period—a total of 5,446,178 individuals.[40] If tax credits were unavailable in those States, the integrated and essential companions to the market reforms would not work as designed—the shared responsibility payments to broaden the market coupled with tax credits to make insurance premiums affordable for individuals with lower incomes. That decou-

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[40] See ASPE Issue Br., *Health Insurance Marketplace: Summary Enrollment Report*, *supra* note 32, at 4.

pling inevitably would trigger adverse selection and instability in the exchanges. Over a period of several years, participation in the insurance market would decrease and premiums would increase.

1. The elimination of tax credits would disproportionately deter participation of those consumers needed to create a balanced risk pool.

The most critical element to maintaining the exchanges' stability involves the attributes of those enrolled, not in terms of raw numbers, but in terms of their relative risk characteristics. As explained above, an insurance plan that attracts only unhealthy subscribers will face upward pressure on premiums in a manner that triggers adverse selection and a pattern of premium increases and participant departures leading to substantial instability.

Eliminating premium tax credits for insurance purchased on FFEs will inevitably produce this effect.

The ACA's reforms are designed to produce a sustainable health insurance market by providing incentives sufficient to induce a rational consumer to participate. A consumer deciding whether to purchase health insurance will compare the annual cost of the insurance to his or her expected medical costs. Particularly when the consumer's budget is stretched—as it often is for low- and middle-income families—the consumer will likely be reluctant to purchase insurance unless projected medical expenses exceed premium costs, and the insurance cost is relatively low. Although insurance provides other important benefits—such as the assurance that unexpected medical costs will not lead to bankruptcy—

such benefits may be less significant to low- and middle-income families than more immediate necessities.

The cost differential produced by eliminating the tax credits is substantial. For example, in States with FFEs, the tax credits reduce insurance premiums to less than $50 per month for 46 percent of uninsured young adults.[41] Without tax credits, the average lowest-cost bronze plan for young adults would cost $163 per month[42]—a difference of more than $1,200 per year.

In the absence of the tax credits, therefore, only consumers with significant anticipated medical expenses will conclude that the unsubsidized premium is a justifiable expenditure compared with more immediate and tangible needs. But without a distribution of enrollees with different expected medical expenses, the risk pool will be unbalanced and "death spiral" characteristics will result.

Indeed, an American Academy of Actuaries analysis found that a key factor in preventing premium increases in the exchanges is the availability of premium assistance tax credits to mitigate the effects of adverse selection:

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[41] Laura Skopec & Emily R. Gee, ASPE Research Br., *Nearly 5 in 10 Uninsured Single Young Adults Eligible for the Health Insurance Marketplace Could Pay $50 or Less per Month for Coverage in 2014* at 3 (Oct. 28, 2013), http://aspe.hhs.gov/health/reports/2013/UninsuredYoungAdults/rb_uninsuredyoungadults.pdf.

[42] ASPE Issue Br., *Health Insurance Marketplace Premiums for 2014* at 3 (Sept. 2013), http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm.

> Changes in overall premium averages will depend on changes in the composition of the risk pool. * * * This in turn will reflect the effectiveness of the individual mandate and premium subsidies designed to increase coverage among young and healthy individuals, combined with the increased ability of high-cost individuals to purchase coverage due to the guaranteed-issue requirement.[43]

Health policy researchers have begun to estimate the potential consequences of withdrawing tax credits, and while their results are, by their nature, estimates, the studies provide insights into how this Court's ruling could affect consumers.[44]

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[43] Am. Acad. of Actuaries, Issue Br., *How Will Premiums Change Under the ACA?* 3 (May 2013), http://www.actuary.org/files/Premium_Change_ACA_IB_FINAL_050813.pdf.

[44] See Linda J. Blumberg, Matthew Buettgens, & John Holahan, *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King *v.* Burwell 3 (Urban Inst. 2015), http://www.urban.org/UploadedPDF/2000078-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf (explaining that, in the absence of tax credits, "the composition of the nongroup insurance market would change significantly" because "[m]any fewer healthy adults would enroll, increasing the average health care cost and risk of those remaining"); Linda J. Blumberg, Matthew Buettgens, & John Holahan, *The Implications of a Supreme Court Finding for the Plaintiff in* King *v.* Burwell*: 8.2 Million More Uninsured and 35% Higher Premiums* (Urban Inst. 2015), http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf; Evan Saltzman & Christine Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* (Rand Corp. 2015), http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf (estimating that the elimination of subsidies in FFE States would result in

2. The elimination of tax credits in FFEs would restrict applicability of the shared responsibility requirement, substantially eroding its effectiveness in promoting balanced risk pools.

The elimination of tax credits for insurance purchased on the FFEs would have an additional, extremely important effect: exempting numerous uninsured individuals from the shared responsibility payment obligation, and thereby eliminating that significant incentive for ensuring balanced risk pools.

The shared responsibility payment obligation does not apply to low- and middle-income individuals and families who could not afford coverage. Thus, the obligation to obtain minimum coverage excludes any individual whose "required contribution * * * exceeds 8 percent of such individual's household income." 26 U.S.C. § 5000A(e)(1)(A). For persons eligible to purchase insurance only through an exchange, the "required contribution" is the "annual premium for the lowest cost bronze plan available in the individual market," reduced by the amount of the premium assistance tax credit to which the person is entitled. *Id.* § 5000A(e)(1)(B)(ii).

The ACA's 8% test emphasizes the fundamental linkage between the shared responsibility payments and the premium assistance tax credits. If there were no tax credits, many consumers would no longer be subject to the shared responsibility payments and would not purchase coverage. Removing the tax credits from the calculus would dramatically impact

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a 70% reduction in enrollment in the individual health insurance market and a 47% increase in unsubsidized premiums).

the number of people who participate in the risk pools, and their characteristics.

That statutory linkage between the tax credits and the shared responsibility payment obligation demonstrates that the provisions are designed to work in tandem to ensure broad participation in the health insurance system. Removing the tax credits would vitiate the payment obligation for a substantial number of Americans. When States, prior to the ACA, implemented market reforms without a financial penalty for failing to obtain insurance, the resulting adverse selection spiral produced unstable insurance markets, providing insurance that was either more costly or less available than before enactment of those state reforms.

The ACA includes two primary countermeasures to market-destabilizing adverse selection: tax credits and the shared responsibility payments. Because shared responsibility payments are dependent on the existence of tax credits, the unavailability of tax credits would mean that neither of the ACA's tools to avoid adverse selection would function as designed.

3. Delinking the tax credits from the integrated reforms would create an unequal system in which residents of FFE states would be relegated to non-functioning marketplaces.

Delinking the tax credits (and, consequentially, the shared responsibility payments) from the market reforms—which indisputably apply nationwide—would leave residents of the 34 States with FFEs significantly worse off than consumers in States with State-run Exchanges.

First, eliminating the tax credits would result in grossly inequitable treatment of consumers in States with FFEs. Those families and individuals would not have the benefit of the tax subsidies available to individual market purchasers in other States with State-based Exchanges (or of the favorable tax treatment available to individuals and families with employer-based coverage). That would make health insurance less affordable—the precise result the tax credits were intended to prevent.

Second, eliminating the tax credits would inevitably produce significantly unbalanced risk pools in FFE States, leaving those States with dysfunctional insurance markets. The consumers who purchase insurance in the absence of tax credits and those who purchase insurance when tax credits are available will have markedly different risk profiles. That is what produces the adverse-selection dynamic.

By way of example, consider the economic decision for a hypothetical 27-year-old from Miami-Dade County, Florida who earns $24,000 per year and seeks coverage on Florida's FFE. That individual would be eligible to purchase a bronze-level plan for $90 per month (after a tax credit of $93 per month).[45]

On an annualized basis, the individual's out-of-pocket cost would be $1,080 (12 monthly premium payments of $90)—but he or she also would have avoided a shared responsibility payment of $325,[46]

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[45] See https://www.healthcare.gov/see-plans/33030/?state=FL.

[46] The shared responsibility payment in 2015 is the greater of $325 or 2 percent of income exceeding $10,300. See 26 U.S.C. § 5000A; note 30, *supra*.

which results in an effective economic cost of $755 per year compared to not obtaining health insurance.

If tax credits were unavailable, the same individual would have to pay $183 per month for the same policy and would be exempt from any shared responsibility payment (because the insurance cost would exceed the 8% threshold). Thus, he or she would face a choice between purchasing health insurance and paying a $2,196 annual premium (twelve monthly premium payments of $183) or not purchasing health insurance and paying no penalty.

With the tax credits, an economically rational individual would acquire health insurance if that individual expected to derive at least $755 per year in economic value from the policy. But if tax credits were unavailable, the individual would acquire health insurance only if he or she expected to derive at least $2,196 per year in economic value from the policy.

There are marked differences in the risk profiles of those who expect to benefit at least $755 per year and the smaller subgroup of those who expect to benefit at least $2,196 per year. This is what produces the adverse-selection dynamic. Only those persons who expected higher medical expenses would opt into the system, which would place upward pressure on premiums and further skew the pool of exchange participants, leading to further increases in premiums and a pool ever-more tilted toward those with higher expected medical expenses.

That same dynamic would play out across different age groups, in different States, and in different low- and middle-income brackets. The ACA's tools for balancing the risk pool would be ineffective, and,

over the course of only a few years, the consequences would resemble the "death spiral" phenomenon accompanying the failed State reform efforts of the 1990s.

Third, eliminating the tax credits in States with FFEs would not just undermine the stability of the FFEs; it also would undermine the market for individual health insurance policies outside the FFE marketplaces.

Insurers may sell individual policies outside the exchanges, but the exchanges and other individual insurance markets are linked through common risk pooling mechanisms, which means that dysfunctional FFEs will adversely affect the stability of non-exchange individual markets.[47] And insurers that

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[47] The exchanges and the off-exchange individual insurance markets are linked in several ways. For example, through the permanent risk adjustment program (42 U.S.C. § 18063), funds from plans in the individual and small group markets that disproportionately attract lower-risk populations are transferred to plans, both inside and outside the exchange, that disproportionately attract higher-risk populations, thus helping insulate these higher-risk plans from losses. Because these transfers are statutorily required, imbalances in the exchange necessarily spill over into the outside market. In addition, a transitional reinsurance program (*id.* § 18061) links the inside and outside markets by providing funding to individual-market plans that incur costs stemming from high-dollar-value claims; these funds are derived from reinsurance contributions paid by health insurance issuers and certain self-insured group health plans. And the temporary risk corridor program (*id.* § 18062), ensures that qualified health plans—whether inside or outside the exchanges—share in the gains or losses resulting from inaccurate rate setting. Under the risk corridor program, plans with costs falling below a target amount transfer payments to HHS, which in turn transfers funds derived solely from those payments to plans with costs exceeding targets. See generally

operate both inside and outside the exchanges must "consider all enrollees * * * to be members of a single risk pool." 42 U.S.C. § 18032(c)(1). In short, most consumers in FFE States who participated in the individual market prior to the enactment of the ACA would find their policies unavailable—or substantially more costly than they were before the federal law was enacted, which is precisely what occurred in connection with the failed examples of state-level reforms. See pages 10–12, *supra*.

These three significant adverse consequences are fundamentally inconsistent with the goals of the ACA, which was intended to achieve nationwide reform and make stable, functioning insurance markets available to all Americans.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Henry J. Kaiser Family Found., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (Jan. 2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf; Ctrs. for Medicare & Medicaid Servs., *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (2012), http://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf; STAFF OF H. COMM. ON RULES, 113TH CONG., TEXT OF H. AMD. TO THE S. AMD. TO H.R. 83 § 227 (Comm. Print. 2014) (limiting funds available for payments under risk corridor program).

The ACA guards against instability in the non-exchange individual markets through the shared responsibility payment obligation, which can be avoided by purchasing insurance on these "outside" markets, and by providing for the sharing of risk among those outside markets and the exchanges, as just discussed.

Respectfully submitted.

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